Oneida Health

Name: _____

MRUN #: _____ DOB: _____

Date of Service: _____ ACCT#: _____

If no label write information in this box.

Declination of SARS CoV-2 (COVID-19) Vaccination

☐ **Employee** ☐ **Resident**

Name: _____ Date of Birth: _____

Oneida Health has recommended that I should receive the COVID-19 vaccination to protect myself, patients, residents, and healthcare workers in this facility. I have had the opportunity to discuss the statement and had my questions answered by a healthcare provider.

I acknowledge that I am aware of the following facts:

- COVID-19 is a serious, contagious respiratory disease that has infected millions and killed hundreds of thousands of people in the United States. The COVID-19 vaccine is a very important tool to help stop and control the current global pandemic.
- COVID-19 vaccination is recommended for me and all other healthcare workers to protect patients and residents from COVID-19 virus, its complications, and death. I understand that I cannot contract COVID-19 from the COVID-19 vaccine.
- I understand that there are no significant vaccine safety concerns. Systemic reactions increase in frequency and severity after the second dose. Most common side effects include fatigue, muscle/joint pains, headache, pain at the injection site, and site redness, which typically resolve within 1-2 days of symptom onset.
- This vaccination may still benefit those that have previously contracted COVID-19. I understand that at this time, experts do not know how long someone is protected from getting sick again after recovering from COVID-19.
- Employees Only: I understand that the proper use of PPE is still mandatory, depending on respective department's requirements. I must still maintain a safe distance from others while unmasked and wash my hands often.
- Residents Only: I understand that I must still maintain a safe distance from others while unmasked, wash my hands often and wear a mask when outside of my living quarters.
- If I contract COVID-19, I may be asymptomatic, or my symptoms can be very mild to severe. I can still spread this illness to others and must contact Infection Prevention/Employee Health or notify a healthcare provider if I have been exposed to someone with COVID-19 or exhibit any new or unusual symptoms.
- The consequences of my refusing to be vaccinated could have potential life-threatening consequences to my health and the health of those with whom I have contact, including all patients/residents in our facilities, my coworkers, my family, and my community.

Despite these facts, I choose to decline the COVID-19 vaccine for the following reason(s):

_____

Name (print): _____

Signature Employee/Resident (Resident Representative if applicable)_____

Date: _____ **Time:** _____ **Department (Employee) / Floor (Resident):** _____

Reference: Centers for Disease Control and Prevention. (2020). *Coronavirus (COVID-19).* Retrieved from https://www.cdc.gov/coronavirus/2019-nCoV/index.html

CONCOVIDDECLINE